Michigan Department of Community Health
ANSI 837 X12N v 4010 Encounter Initiative
Medicaid Health Plan and Special Health Plan
Frequently Asked Questions

A. General Questions

A.1 Question: **Plans currently submit files using a dial-up system. Is there a faster way to accomplish this, e.g. High-speed Internet/encryption of the data? (5/7/03)**

Response: HTTPS and SSLFTP are options for submitting 837 transactions. Plans may email a request for assistance to MDCHEncounterData@Michigan.gov.

A.2 Question: **It is understood that plans should already be meeting with their provider networks to work through the upcoming changes. Is MDCH also arranging independent sessions with providers? (9/20/02)**

Response: MDCH has been holding joint provider meeting sessions with BC/BS on 837 issues, and will continue to do so.

A.3 Question: **Is there a way to post questions on the MDCH website? (Revised 3/10/03)**

Response: MDCH does not have a site to post questions. However questions can be emailed to MDCHEncounterData@Michigan.gov

A.4 Question: **Since some elements that are currently collected on the proprietary encounter data format will not be part of the 837, can the plans disregard issues related to these data elements on their more recent Corrective Action Plans? (9/20/02)**

Response: The Department has been aware that certain elements would not be part of the 837 and has de-emphasized these issues during the recent Data Quality Improvement Meetings with the plans.

A.5 Question: **Have there been any decisions on how the Maternity Case Rate will be handled with the transition to the 837? (5/1/03)**

Response: The maternity case rate will be paid via the 820 transaction. For questions regarding this issue, please send email to MDCH834/820@Michigan.gov.

A.6 Question: **Will an electronic copy of the updated Medicaid Provider File be made available to the plans again at some point in the future? (9/20/02, Revised 3/10/03)**

Response: MDCH expects to produce and make the file available to the plans on a quarterly basis. The production schedule will be January, April, July and October.

A.7 Question: **Will the new 4410 layout be put on the Internet? (9/20/02, Revised 3/10/03)**

Response: The 4410 layout is the error report for the proprietary format. The error report for the 837 transactions is the 4950. This was sent to the plans in November 2002. If you did not receive a copy of the layout, please send a request to MDCHEncounterData@Michigan.gov and the file layout will be forwarded to you.

A.8 Question: **How do the MHPs submit services for which they have reimbursed the provider on a FFS basis? (9/20/02)**

Response: These should be submitted in the same manner as capitated services. The "Claim/Encounter Indicator" should be defaulted to "RP" for all encounter data reporting, regardless of whether or not the service was capitated or reimbursed by the plan on a FFS basis.

A.9 Question: **How are pharmacy records to be handled? (1-28-03)**

Response: Until further notice these records should be submitted in the proprietary format. Any questions regarding submission of psychotropic drugs should be directed to First Health. Their website address is http://Michigan.FHSC.com.

A.10 Question: **Is there a crosswalk of the current proprietary format for encounters to the 837 Professional and 837 Institutional formats for Encounters? (1-28-03, Revised 3/10/03)**

Response: The crosswalks are in Sections 2 and 3 of the *MDCH Supplemental Instructions for Encounter Data Submission Manual* that is currently available on the MDCH website at http://michigan.gov/mdch. Click on Providers (left side of screen), then HIPAA Implementation Materials (right side of screen). The manual is in the section titled Data Clarification Documents.

A.11 Question: **MDCH has recently issued policy letter L02-35 stating that MDCH will delay implementation of the 2003 HCPCS changes scheduled for implementation on 1/1/03. Will the encounter file accept codes that were deleted effective 1/1/03 without generating any type of error message? If a plan chooses to implement some or all of the new 2003 codes before MDCH does, will these codes be accepted on the encounter file, or will they generate errors? (1-28-03)**

Response: MDCH will accept the new codes for service dates of 1/1/03 and after. The HCPCS codes terminated as of 1/1/03 will be accepted through the encounter system with dates of service through 3/31/03.

A.12 Question: **In another meeting late last year, there was some discussion about carrying long-term and home health care information in the claims. I don't see anything specific to these requirements in the documentation. Are there any special requirements for these types of encounters? (1-28-03)**

Response: The requirements for reporting encounter data specific to long-term care and home health care information are outlined in the *MDCH Supplemental Instructions for Encounter Data Submission Manual.* Specifically, long-term care and home health encounters are to be reported using the 837 v 4010 Institutional transaction. This is a change for home health encounters which were previously reported as professional. As a result of home health services being required to be reported using the 837 Institutional format, Revenue Codes **and** HCPCS Level I or II procedure codes are required. If both revenue code and procedure code are not present on home health encounters, the encounter will be rejected.

A.13 Question: **We have searched through many of the links on Michigan's website and have been unable to locate an electronic copy of the documentation. Is this information available someplace? In particular we are looking for Appendix D & G but having the entire document in electronic format would be a great benefit. (1-28-03, Revised 3/10/03)**

Response: The *MDCH Supplemental Instructions for Encounter Data Submission Manual* is posted on the MDCH website, http://michigan.gov/mdch. Click on Providers, then HIPAA Implementation Materials. The manual is in the section titled Data Clarification Documents.

A.14 Question: **Currently we receive a 4410-formatted error file that we download from the state. Will the error/edit report generated be in the same format or another (e.g. 997 or 227)? Will we continue to download it or will it be emailed to us (understanding that there maybe a separate process for testing right now and production in the future)? (1-28-03)**

Response: MDCH will generate 997 Functional Acknowledgements and TA1 Interchange Acknowledgements to communicate errors related to translation. Additionally, an error file will be created, listing any errors found during the processing of the health plan's encounter transactions. The Error Report File is a 4950 file, replacing the 4410 file that is currently produced. The format is very similar to the 4410 file. The health plan will need to download the error file from the DEG.

A.15 Question**: We have not seen any concrete decision on the pricing/financial data to be sent on the 837 Outbound Transaction. Will the COB information be required/mandatory? (1-28-03)**

Response: The reporting of financial data elements will be optional for encounter submissions January 1, 2003 through September 30, 2003. Plans are encouraged to report this information, but are not required to do so.

A.16 Question: **We have DQIP specifications for edit validation that is conducted prior to submission to the state. Will the state continue using the DQIP specifications? If so, what is the latest version? If not, are there new edit specifications we should be validating against? (1-28-03, Revised 3/10/03)**

Response: MDCH is in the process of revising the DQIP packet. Additional information regarding the revised packets will be provided to the health plans at a later date. The most recent version of the 837 Encounter Error Catalog is dated 2/26/03 and is part of the *MDCH Supplemental Instructions for Encounter Data Submission Manual* that is posted on the MDCH website.

A.17 Question: **When the file is successfully translated and loaded into the test encounter system for processing, will the processing include the DQIP edit validations? Will the error threshold for batch rejection remain at 3% or change? (1-28-03)**

Response: The DQIP specifications are currently being revised. Edits applied to the proprietary format will result in a rejection of the entire batch if greater than 30% of the records in the batch are rejected. This particular edit is not part of the group of 837 edits.

A.18 Question: **Are plans only allowed to submit a maximum of 5,000 encounters per batch? The Professional Data Clarification Document notes that MDCH accepts a maximum of 5,000 CLM segments in a single transaction (ST-SE), as recommended by the HIPAA-mandated implementation guide. (1-28-03)**

Response: Health plans are not limited to a maximum of 5,000 encounters per batch. MDCH does not have an established limit on the number of encounters that can be submitted per 837 Encounter transaction. MDCH is following the recommendations outlined in the Health Care Claim: 837 v4010 Implementation Guides of limiting the maximum number of CLM segments in a transaction set (ST-SE) to 5,000. There are no limitations on the number of ST-SE transactions within a functional group (GS-GE) or an interchange (ISA-ISE). Health plans should refer to Appendix A of the Implementation Guides for information on the interchange control structure. Health plans should consider the capabilities of their systems when making decisions about size of encounter transactions.

A.19 Question: **What type of acknowledgement is the state using to let us know the file was received (e.g. 997)? (1-28-03)**

Response: MDCH will produce an Acknowledgment upon the completion of the translation of the submitted file. The Acknowledgment will be either a 997 Functional Acknowledgment or a TA1 Interchange Acknowledgement. The TA1 verifies the envelope only. A TA1 will be produced when MDCH identifies a serious problem with the health plan's file during translation. Health plans can retrieve the Acknowledgements from their mailbox via the DEG. Acknowledgments are sent to the health plan mailbox within minutes of sending the file to the DEG.

A.20 Question: **I need to know about the pharmacy data that is not changing formats at this time. We have not sent anything for February (January data). Should we have sent the pharmacy data or should we continue to hold onto the file and send everything together once the okay is received from you at MDCH? (3/10/03)**

Response: Plans are expected to send pharmacy in the proprietary format.

A.21 Question: **We need to know how to handle claims that were originally processed in 2002 that get adjusted after the May 1 cutoff. We were told that for 'void' or 'replacements' we could use the new format, but the FAQ document states they should be sent in the original format. Please clarify. (3/10/03)**

Response: Voids or replacements must be submitted in the same format as the original record. Therefore, if a record was originally submitted in the proprietary format, a void or replacement of that record must also be in the proprietary format. Similarly, if an "original" encounter is submitted in the 837 formats, adjustments must also be submitted in the 837.

During DQIPs with some health plans, MDCH discussed claims that were originally processed in 2002 that may require adjustments after the May 1, 2003 cutoff. It was our understanding that the number of records that were processed in 2002 that would still require some type of adjustment 5/1/03 and after

would be relatively small. It is recognized that this is a potential problem for some health plans. The Department recommends that from this point on, the plans send all original non-pharmacy records in the 837 formats, regardless of paid/process date or date of service. This should help to reduce the number of records for which adjustments will become problematic as of 5/l/03.

A.22 Question: **I noticed that the 837 timelines are based on date of service verses paid/processed date. I assume that we can submit encounters with dates of service from previous time periods, even if it is the first time we are sending the encounter? For example, what if a claim has a date of service from December, but doesn't get paid until now? We would not normally (in the proprietary) send the claim until it is paid/processed. Will this be okay? (3/10/03)**

Response: Yes. Non-pharmacy encounters with dates of service prior to l/l/2003 that have not already been submitted on the proprietary format may be submitted via the 837 transactions.

A.23 Question: **Don't we have two NEW provider IDs? One for Regular members and one for MCEP members? (3/10/03)**

Response: You do have two ID numbers. However, when submitting encounters, you should always use the "voluntary" number, not the "automated" (or MCEP) number.

A.24 Question: **Does MDCH want denied claims included in the 837P Outbound transmission? These denials include claims that reject payment for any number of reasons: lack of authorization, duplicate claim, missing diagnosis/procedure codes, invalid diagnosis/procedure codes, member ineligible, etc. (3/10/03)**

Response: MDCH would like plans to report services that have been denied for lack of authorization, non-covered service, non-designated provider, etc. These should be reported with the appropriate adjustment code. Please refer to the *MDCH Supplemental Instructions for Encounter Data Submission Manual*, Section 3, Institutional and Professional Crosswalk, Field 60 and Appendix E. This allows MDCH to assess total services that beneficiaries are receiving, even if the service is not covered by the plan.

You have also referenced services that have been denied because of missing or invalid diagnoses or procedure codes, the member is ineligible or the claim is a duplicate. These records should not be submitted to the State. Instead, the plan should resolve the problems with these claims and then send the records.

A.25 Question: **Currently, we have until the 15th of the month to resolve errors with encounter submissions in the proprietary format. This is accomplished by submitting the file early (around the llth), receiving the error report and then re-submitting encounters by voiding the original encounter and replacing with a new original encounter. Will this process be the same with encounters submitted in the 837 formats? If yes, will you provide assistance on how voids are to be reported? The only options in the BTH02 segment are "O" (Original) and "R" (Reissue). (3/10/03)**

Response: The Department will retain the same schedule of submissions for the 837 transactions as was required with the proprietary format. The "original" and "reissue" referenced in relation to BHT02 addresses the electronic transmission status of the 837 batch, not the billing (or reporting) status of the individual encounters.

To submit adjustments to individual institutional encounters, including voids, please refer to Loop 2300, Claim Information, CLM05-3 in the 837 Institutional Implementation Guide. As directed in the Implementation Guide, the allowable values denoting replacements and voids in the *Claim Frequency Type Code* field are found in the UB-92 manual. The value is actually the third digit of the *Type of Bill* that is reported in the UB–92. Also, please refer to the section on corrections in Section 8 of the *MDCH Supplemental Instructions for Encounter Data Submission Manual.*

B. Submitter Name

B.1 Question: **The NM109 segment element of Loop 1000A is noted to require the 4-character billing agent ID assigned by MDCH. What value should be placed in this area for a plan? (1-28-03)**

Response: Health plans approved by MDCH as an electronic biller have been assigned a 4-character billing agent identification number, for example "00XX". This is the same number that health plans submitted on the proprietary encounter format in Field 3 – Autobiller ID.

C. Billing/Pay-to Provider Information

C.1 Question: **We are building a crosswalk from our provider specialties to the HIPAA compliant taxonomy codes. We noticed that on the State list of taxonomy codes (Appendix D – Provider Taxonomy to Proprietary Provider Types) the alpha character on the end of the taxonomy code is "X". Doesn't the actual taxonomy code have an alpha character of "N" or "Y" at the end, representing the Training/Education Requirement Indicator (TER)? (1-28-03, Revised 4/25/03)**

Response: The "N" and "Y" may have been part of an earlier version of the taxonomy codes. In September 2002, MDCH published a crosswalk from the Encounter Data proprietary provider types to the taxonomy codes that were in place at that time. In February 2002, the National Uniform Claim Committee (NUCC) revised the taxonomy codes for submission dates 4/1/03 and after. MDCH has not yet loaded the new values, but expects to do so in the near future. The taxonomy codes can also be accessed at http://www.wpc-edi.com/codes/.

C.2 Question: **We've run into several instances in our conversion of our provider specialty codes to the taxonomy codes (PRV 2310B) where this is a one-to-many relationship instead of a one-to-one relationship. What values should we use to represent the following?**

OTHER PROFESSIONAL PROVIDERS NOS
NURSING SERVICE RN/LPN
PHYSICIAN/SPECIALIST NOS
ORTHOTIST/PROSTHETIST
FACILITY PROVIDER NOS
NON-EMERGENCY TRANSPORTATION (1-28-03, Revised 4/25/03)

Response: MDCH has provided the health plans with a crosswalk from provider taxonomy code to proprietary provider type. This crosswalk can be found as Appendix D of the *MDCH Supplemental Instructions for Encounter Data Submission Manual* that is currently available on the MDCH website at http://michigan.gov/mdch. Click on Providers (left side of screen), then HIPAA Implementation Materials (right side of screen). The manual is in the section titled Data Clarification Documents. The taxonomy codes are more detailed than the MDCH Encounter Data Provider Types and therefore a one-to-one mapping is not possible. However, since the plans have been using the proprietary provider types for some time, this crosswalk should provide a starting point for the mapping process. The proprietary provider types referenced above are included in the crosswalk. This crosswalk will be revised by MDCH in the near future to accommodate the National Uniform Claim Committee (NUCC) revisions that were effective 4/1/03.

D. Subscriber Information Questions

D.1 Question: **In the documentation we have from Michigan, it notes the use of S(econdary) and T(ertiary) in the SBR segments, but it doesn't mention the use of P(rimary). Is this just an oversight or is P actually not accepted? (1-28-03)**

Response: Loop 2000B Subscriber Hierarchical Level, SBR01 Payer Responsibility Sequence Number Code identifies the level of responsibility of the Destination Payer identified in Loop 2010BB, in the case of encounters this will be MDCH. MDCH will never have primary (P) financial responsibility for services being reported by the health plan. MDCH may have secondary (S) or tertiary (T) responsibility. The health plan will have primary (P) responsibility, unless another payer has been identified as having financial responsibility. In the event of another carrier being identified, the other carrier would have (P) primary responsibility, the health plan (S) secondary responsibility and MDCH (T) tertiary responsibility. The level of responsibility for the health plan and any other identified payers

is reported in Loop 2320 Other Subscriber Information, SBR01 Payer Responsibility Sequence Number Code. For example:

Health Plan is the Only Payer:

Loop/Segment/Element	Payer	Level of Responsibility
2000B/SBR/SBR01	MDCH	(S) Secondary
2320/SBR/SBR01	Health Plan	(P) Primary

Commercial Carrier and Health Plan are Payers:

Loop/Segment/Element	Payer	Level of Responsibility
2000B/SBR/SBR01	MDCH	(T) Tertiary
2320/SBR/SBR01 (One Iteration)	Commercial Carrier	(P) Primary
2320/SBR/SBR01 (One Iteration)	Health Plan	(S) Secondary

D.2 Question: **For the 837 Institutional and 837 Professional, the SBR segment of Loop 2000B includes a group number and group name. Since this subscriber loop is related to the destination payer (MDCH), I'm assuming that the group data here is determined by MDCH and may not be the same group data used in Loop 2320 for Other Subscriber. In Loop 2320, we are using our plan specific numbers for MDSS, MCEP and MICHILD. What should we use for the group number and group name in Loop 2000B for MDSS, MCEP and MICHILD? (3/10/03)**

Response: Loop 2000B Subscriber Hierarchical Level SBR03 Insured Group or Policy Number is a situational data element. This element represents any MDCH assigned group or policy numbers. MDCH does not require the health plan to report a value for MDSS, MCEP or MICHILD at this time.

Loop 2000B Subscriber Hierarchical Level SBR04 Insured Group Name is a situational data element. This element represents any MDCH assigned Group Names. MDCH only requires that the health plan report the value "MICHILD" when the subscriber is enrolled in the MIChild Program. This is addressed in the Institutional and Professional Data Clarification Documents issued by MDCH. There are no requirements to report MDSS or MCEP at this time.

The health plan should not submit the plan specific numbers from the 2320 Loop in 2000B Loop.

D.3 Question: **Because we are sending Medicaid only claims data on the 837P Outbound, would we ever populate Loop 2000B, SBR09 with anything other than "MC"? (3/10/03)**

Response: If you submit Medicaid only records, the field should always be populated with "MC".

E. Payer Information

E.1 Question: **Does Michigan require the use of REF 2010BB, Payer Secondary Identification? It appears that we don't have anything on our system to populate this information but there may be hard-coded values we could send. (1-28-03)**

Response: The 837 Professional Loop 2010BB and the 837 Institutional 2010BC Payer Name, REF01 and REF02 Payer Secondary Identification are situational and not required to be reported at this time.

F. Patient Information

F.1 Question: **Loop 2000C, PAT Patient Information. The Implementation Guide (IG) states this is required, but lists choices for patient relationship to subscriber and "self" isn't one of the options. What do we send? (1-28-03)**

Response: MDCH does not expect the health plan to report Loop 2000C, PAT Patient Information. As stated in the Implementation Guide, Loop 2000C Patient Hierarchical Level is required only when the patient is a different person than the subscriber. MDCH expects that the information about the Medicaid beneficiary would be reported in Loop 2000B Subscriber Hierarchical Level.

G. Claim Information

G.1 Question: **How will a plan know if a batch has been completely received? (9/20/02)**

Response*:* If an incomplete batch is received, the translator will reject it because it is syntactically incorrect. If this occurs, the State's IS staff will contact the plan. For less severe errors, such as rejection of part of a batch, the translator will inform the plan electronically.

G.2 Question: **One of the provider fields on the 837 includes a Medicaid Provider Number as one of the possible identifiers that a plan can submit. What about those cases where the same Medicaid Provider Number has been issued to more than one provider or the same provider has more than one Medicaid Provider Number? (9/20/02)**

Response: MDCH issues Medicaid Provider Numbers to providers for a specific practice location. Therefore, a provider may have more than one Medicaid Provider Number and the Department will be able to link any of those numbers to that provider. The same Medicaid Provider Number is not issued to more than one Medicaid enrolled provider, and therefore this should not be a problem. However, the Department does recognize that tax IDs may be issued to groups of providers, and therefore, all providers within the group may have the same tax ID. The tax ID (or Social Security Number) is collected in the NM segment. The Medicaid Provider Number or State License Number is collected in the REF segment.

G.3 Question: **Will home health services be reported on the 837 Professional or the 837 Institutional Form? (9/20/02)**

Response: Services should be reported in the 837 Institutional transaction.

G.4 Question: **For institutional claims, the *MDCH Supplemental Instructions for Encounter Data Submission Manual* states that MDCH will use CLM05-1, which is the first two positions of Type of Bill code, to map place of service. Please provide additional information regarding the relationship between record type and place of service for institutional records. (1-28-03)**

Response: This is explained in greater detail in Section 4, page 3 of *MDCH Supplemental Instructions for Encounter Data Submission Manual.* Please refer to the paragraph titled *Type of Bill* for a more complete explanation and examples. However, to paraphrase a few of the instructions from this paragraph: The first digit of the *Type of Bill* identifies the type of facility; the second digit is the bill classification and conveys information on the place of service; and the third digit is the frequency code and identifies the type of billing (e.g. – original, interim, final, adjustment, void). Please refer to the UB Manual for allowable values for each of the three numbers that make up the *Type of Bill.* For example, a *Type of Bill* value of 131 would translate to:

Type of Facility = 1 = Hospital
Bill Classification = 3 = Outpatient (includes ER)
Frequency Code = 1 = Admit through Discharge Claim

G.5 Question: **What values may be used for record type for professional records? (1-28-03)**

Response: Allowable values for Loop 2300 Claim Information, CLM05-3 Claim Frequency Code include:
1 = Original
7 = Replacement
8 = Void

G.6 Question: **The following values do not appear to be available on our existing system. We can work to start collecting this information in the future but have no current time frame when the information would be available. Will we fail compliance if the following information is not provided?**

CLM11-1 & 2 - RELATED-CAUSES CODE
CLM11-4 - AUTO ACCIDENT STATE OR PROVINCE CODE
CLM11-5 - COUNTRY CODE
CLM12 - SPECIAL PROGRAM CODE (Available for physician but not hospital)
HI02 –2 - ADMITTING DIAGNOSIS/PATIENT'S REASON FOR VISIT (1-28-03)

Response: Loop 2300 Claim Information CLM11-1 and 11-2 Related Causes Code, CLM11-4 Auto Accident State of Province Code, CLM11-5 Country Code are defined as situational data elements. MDCH will not be editing these data elements at this time. CLM12 Special Program Code is required to be reported and failure to do so will result in an Information Only edit at this time.

The 837 Institutional Loop 2300 Claim Information HI02-2 Admitting Diagnosis/Patient Reason for Visit is required to be reported by the health plan. Failure to report will result in an Informational Only edit at this time.

G.7 Question: **837 Institutional Loop 2300, DTP Discharge Hour. The Implementation Guide (IG) says this segment is required on all final inpatient claims/encounters. We do not have discharge times. What do we send? As a related issue, several segments ask for times. We do not store any times in our system, so can't send any of them. (1-28-03)**

Response: Loop 2300 Claim Information, DTP Discharge Hour is defined as a situational data element required on all final inpatient claims/encounters. It is the value reported in FL21 on the UB-92 submitted by the provider. If this value is not reported by the provider a value of "1100" may be reported. The same would be true for other time data element requirements. This element is not being edited by MDCH at this time.

G.8 Question: **The 837 Institutional Loop 2300, DTP Statement Dates. Our health plan does not understand what date is wanted here. (1-28-03)**

Response: Loop 2300 Claim Information, DTP Statement Dates is required and is the equivalent to FL6 on the UB-92 submitted by the provider. It only relates to 837 Institutional encounters. The "statement from and to" dates represent the beginning and ending dates of the period included on this encounter. For services received on the same day, both will be the same date. For acute inpatient admissions the "statement from" date will likely be the same as the admission date. For long term care encounters, the "statement from" date may or may not represent the admission date. MDCH will use this data element primarily for inpatient admissions and long term care encounters. The "statement to" date will be used to derive the discharge date.

G.9 Question: **The 837 Institutional Loop 2300, CL1 Institutional Claim Code, fields CL101 Admission Type Code and CL102 Admission Source Code. The Implementaion Guide says to use this segment for inpatient. We don't store these two fields. (1-28-03)**

Response: Loop 2300 Claim Information, CL1 Institutional Claim Code, CL101 Admission Type Code and CL102 Admission Source Code are identified as situational data elements in the Implementation Guide. MDCH expects to utilize this data and will require the health plan to report it for encounters related to inpatient admissions.

G.10 Question: **837 Institutional Loop 2300, AMT Patient Estimated Amount Due. Is this segment required? (1-28-03)**

Response: Loop 2300 Claim Information, AMT Patient Estimated Amount Due is a situational data element. MDCH acknowledges this situation would not be common within existing Medicaid business practices. However, if the situation existed where there was a Patient Estimated Amount Due, MDCH would expect the health plan to report it. MDCH will not edit this data element at this time.

G.11 Question: **837 Institutional Loop 2300, AMT Patient Paid Amount. We don't store this data in our system. (1-28-03)**

Response: 837 Institutional Loop 2300 Claim Information, AMT Patient Paid Amount and 837 Professional Loop 2300 Claim Information, AMT Patient Amount Paid are situational data elements. MDCH acknowledges this situation would not be common within existing Medicaid business practices. However, if the situation existed where the patient paid any amount toward the claim, MDCH would expect the health plan to report it. MDCH will not edit this data element at this time.

***G.12 Question*: Loop 2300, REF Service Authorization Exception Code. The Implementation Guide describes what this means. The guide says "check with your state Medicaid to see if this applies in your state." Does it? (1-28-03)**

Response: Loop 2300 Claim Information, REF Service Authorization Exception Code is used to report the reasons required authorizations were not obtained prior to performing the service. MDCH does not require the health plan to report this data.

***G.13 Question*: Loop 2300, REF Prior Authorization or Referral Number. Does the state need to see our internal referral/authorization numbers? What will be done with them? The way these are stored in our system makes it difficult to link authorization number to claim number. We would rather not attempt it, unless it's needed. (1-28-03)**

Response: Loop 2300, REF Prior Authorization or Referral Number refers to any authorizations required and generated by MDCH. Health plans would not report this data element. Authorizations or referrals generated by the health plan are reported in Loop 2330B Other Payer Name, REF02 Other Payer Prior Authorization or Referral Number. MDCH will not edit this data element at this time.

***G.14 Question:* Loop 2300, REF Medical Record Number. Is this segment required? (1-28-03)**

Response: Loop 2300 Claim Information, REF Medical Record Number is a situational data element. It is a data element reported by the provider and is useful to the provider as another identifier that can be used for tracking. MDCH does not require this element.

***G.15 Question:* 837 Institutional Loop 2300, CR6 Home Health Care Information, and several other segments about home health care. We don't have any of the data requested available, so won't be able to send it. Is that going to be a problem? (1-28-03)**

Response: Loop 2300 Claim Information, CR6 Home Health Care Certification is defined as being required for Home Health Claims. MDCH will not edit this segment at this time.

***G.16 Question:* 837 Institutional Loop 2300, CR7 Home Health Care Plan Information and HSD Health Care Services Delivery. The plan does not receive this information. Is it required? (1-28-03)**

Response: Loop 2305 Home Health Care Plan Information, CR7 Home Health Treatment Plan Certification and HSD Health Care Services Delivery are situational and MDCH does not require the health plan to report this information at this time.

***G.17 Question:* I have observed that some claims have more than one E-Code (diagnosis). Will that be a problem, or can we send more than one E-Code? (1-28-03)**

Response: The 837 format accomodates reporting more than one E-Code.

***G.18 Question:* Loop 2300 Claim Information; Principal Procedure Information (Implementation Guide, Page. 242). Reference Designator HI01-1; Name: 1270 Code List Qualifier Code. This requires input of either codes BP (Health Care Financing Administration Common Procedural Coding System Principal Procedure) or BR (International Classification of Diseases Clinical Modification ICD-9-CM Principal Procedure). Our Health Plan sometimes uses CPT codes and would like to know where they would be placed. (1-28-03)**

Response: Loop 2300 Claim Information, HI01-1 relates to 837 Institutional encounters only. It is the "qualifier" defining the data element that is reported in Loop 2300 Claim Information, HI01-2 Principal Procedure Code. This is a required field. The procedure code is the equivalent of FL 80 Principal Procedure Code on the UB-92 submitted by the provider. MDCH requires that health plans report an ICD-9-CM code in this field. Therefore the allowable qualifier in Loop 2300, HI01-1 Code List Qualifier Code is BR – International Classification of Diseases Clinical Modification (ICD-9-CM) Principle Procedure. The 837 Institutional encounter accommodates the reporting of CPT codes in Loop 2430 Service Line Adjudication Information, SVD03-2 Procedure Code. However, the health plan should note that this does not meet the requirement for reporting the Principal Procedure.

G.19 Question: **837 Institutional Loop 2300, HI Principal Procedure Info, HI01-4 Date Time Period. Does this date refer to the date of service, or the date the procedure code became eligible, or what? The Implementation Guide isn't clear. (1-28-03)**

Response: Loop 2300 HI Principal Procedure Information, HI01-4 Date Time Period refers to the date the Principal procedure reported in Loop 2300 HI01-2 was performed.

G.20 Question: **837 Institutional Loop 2300, HI01-HI12-4 Occurrence Span Code. Are the Medicaid health plans required to complete this segment and data elements? (1-28-03)**

Response: Loop 2300 Claim Information, HI01 through HI12 Occurrence Span Code is defined as a situational data element. It is equivalent to FL36 on the UB-92. If the situation reported fits any of those described in codes 70 – Z9 (UB 92 – Page I-49 – I-50) and it is reported by the provider on the UB-92 or 837, the Health Plan should pass it on to MDCH.

G.21 Question: **837 Institutional Loop 2300, HI01-HI12-4 Occurrence Code. Are the Medicaid health plans required to complete this segment and data elements? (1-28-03)**

Response: Loop 2300 Claim Information, HI01 through HI12 Occurrence Code is defined as a situational data element. It is equivalent to FL 32 - 35 on the UB-92. If any of the codes identified in 01 – L9 of the UB-92 manual (UB 92 – Page I-44 – I-47) describe the situation being reported and it is on the UB-92 or 837 submitted by the provider, the health plan should pass it on to MDCH.

G.22 Question: **837 Institutional Loop 2300, HI01-HI12-2 Value Code. Are the Medicaid health plans required to complete segment and data elements? (1-28-03)**

Response: Loop 2300 Claim Information, HI01-HI12-2 Value Code is defined as a situational data element. It is equivalent to FL39, FL40 and FL41 on the UB-92. It is not expected that most of the codes listed on Page I-55 – I-61 of the UB 92 will apply; however, if the provider submits the data, the health plan should pass it on to MDCH.

G.23 Question: **837 Institutional Loop 2300, HI01-HI12-2 Condition Code. Are the Medicaid health plans required to complete this segment and data elements? (1-28-03)**

Response: Loop 2300 Claim Information, HI01-HI12-2 Condition Code is defined as a situational data element. It is equivalent to FL24 through FL30 on the UB-92. It is not expected that most of the codes listed on Page I-31 – I-40 of the UB 92 will apply, however if the provider submits the data, the health plan should pass it on to MDCH.

G.24 Question: **837 Institutional Loop 2300, QTY101 Claim Quantity Qualifier. Should the value reported always be CA? (1-28-03)**

Response: Loop 2300 Claim Information, QTY101 Claim Quantity Qualifier value should be reported when all the days being reported by the health plan are covered by the health plan. If there are days reported that are not covered by the health plan, MDCH expects that the health plan would report this with a qualifier value of "NA", Number of Non-Covered Days. This segment repeats up to four times and accommodates reporting more than one value as necessary.

G.25 Question**: Loop 2300, HCP Claim Pricing/Repricing Information. Does this apply to the repricing firm? Is this segment required of the health plan? (1-28-03)**

Response: Loop 2300 Claim Information, HCP Claim Pricing/Repricing Information is situational. It does apply to the repricing firm. MDCH does not require this segment to be reported.

G.26 Question: **Will we be able to send invalid secondary diagnosis codes? When we tested with BCBS they rejected the entire file if there was an invalid diagnosis code anywhere on the file. Will the State do the same thing? (3/10/03)**

Response: MDCH edits are set to reject an encounter with an invalid primary diagnosis. It is the intent of MDCH that an invalid additional diagnosis (e.g. secondary or tertiary) will result in an informational

only edit. However, because the system is in the developmental stage, it is important that during B2B testing the plans and MDCH verify that the system is functioning properly.

G.27 Question: **When a surgical procedure is done, we send an institutional record placing the surgical procedure code in the procedure code field. Examples of this come back from Claredi with an error saying it's not a valid CPT or HCPCS code. Can you shed some light on this? (3/10/03)**

Response: Inpatient surgical procedure codes should not be reported in the procedure code field. Surgical procedures are reported in Loop 2300, Principal Procedure Information and Other Procedure Information. Refer to the *MDCH Supplemental Instructions for Encounter Data Submission Manual*, Section 3, Institutional Crosswalk, field 29, page 7.

H. Attending Physician

H.1 Question: **837 Institutional Loop 2310A, NM1 Attending Physician Name and REF02 Attending Physician Secondary Identifier. We don't store this data in our system and can't send it. This applies to all segments about Attending Physician. (1-28-03)**

Response: Loop 2310A NM1 Attending Physician Name is required on all inpatient claims and encounters. Unlike the 837 Professional encounter where the Rendering Provider is reported, the 837 Institutional encounter is generated by a facility or agency. The Attending Physician Loop is intended to identify the licensed practitioner who has primary responsibility for the patient's medical care and treatment. MDCH will not edit this information at this time.

I. Operating Physician

I.1 Question: **837 Institutional Loop 2310B, NM1 Operating Physician Name. We don't store this data in our system and cannot send it. (1-28-03)**

Response: The health plan is required to report Loop 2310B Operating Physician Name, NM1 Operating Physician name when any surgical procedure is reported on the encounter. MDCH will not edit this information at this time.

I.2 Question: **837 Institutional Loop 2310B, REF02 Operating Physician Secondary Identifier. Are the Medicaid health plans required to complete segment and data elements? (1-28-03)**

Response: The health plan should report the Operating Physician's Medicaid Provider ID or state license number if it is available. MDCH will not edit this information at this time.

I.3 Question: **837 Institutional Claims, Loop 2310B stipulates that when any surgical procedure code is listed, the operating provider information must be sent. When such an instance occurs, the surgical claim would be sent as a separate physician claim and not as part of an institutional claim. The question has been raised as to whether it is really necessary for us to send this information in the hospital claim when it has already been provided elsewhere. (1-28-03)**

Response: Loop 2310B Operating Physician Name is a situational data element. The Implementation Guide defines Operating Physician information as being required when a surgical procedure code is reported on the claim/encounter. The guidelines do not indicate that the information is not required if reported by the physician on the professional claim.

J. Other Provider Name

J.1 Question: **837 Institutional Loop 2310C, NM1 Other Provider Name. Not sure what to send here. The only information we have that might apply is the provider of service, which is the same as the billing provider. Do you want the same data sent in both places? (1-28-03)**

Response: Loop 2310C Other Provider Name, NM1 Other Provider Name is not to be reported if it is the same as the Billing Provider reported in 2010AA.

K. Service Facility Information

K.1 Question: **837 Institutional Loop 2310E, REF01 Reference Identification Qualifier (Service Facility Secondary Identification) and REF02 Laboratory or Facility Secondary Identifier. Are the Medicaid health plans required to complete these segments and data elements? (1-28-03)**

Response: 837 Institutional Loop 2310E Service Facility Name REF01 and REF02 Service Facility Secondary Identification are required when the location of health care service is different than that carried in the 2010AA (Billing Provider) or 2010AB (Pay-to Provider) loops. See the Data Clarification Document for allowable identifiers.

L. Other Subscriber Information

L.1 Question: **Loop 2320 Other Subscriber Information, SBR Subscriber Information. Are the Medicaid health plans required to complete this segment and data elements? (1-28-03)**

Response: MDCH does require the health plan to report Loop 2320 Other Subscriber Information, SBR Subscriber Information. The health plan will be identified as a payer in Loop 2330B Other Payer Name. The information reported in this iteration of Loop 2320 is specific to the subscriber's coverage through the health plan. In the event of additional payers, Loop 2320 Other Subscriber Information would be repeated and would be specific to its respective 2330B Other Payer Name Loop.

L.2 Question: **Does Michigan require the use of REF 2330A, Other Subscriber Secondary Information? It appears that we don't have anything on our system to populate this information but there may be a hard-coded value we could send. (1-28-03)**

Response: Loop 2330A Other Subscriber Name, REF01 and REF02 Other Subscriber Secondary Information are situational. MDCH does not require the health plan to report additional subscriber identification numbers at this time.

L.3 Question: **We are working on the 2330B Loop, Other Payer. Our coordination of benefit (COB) information in our system is not complete nor accurate. We implemented a Liability and Recovery System about mid-year 2002. Since that time we have been doing a better job of recording COB information, but still not at the level of the carrier codes we got from the website. At best, our data is 40% accurate and by no means complete. Do you want us to submit what we have, or is it best not to submit any of the COB information until it is more accurate and complete? (3/10/03)**

Response: The Department recommends that health plans submit all COB information that is available.

M. Other Payer Information

M.1 Question: **Does Michigan require the use of NM1 2330B, Other Payer Name? The values required in NM109 are assigned by MDCH. We will need a list of these values if we are to send them. (1-28-03)**

Response: Loop 2330B Other Payer Name, segment NM1 is required for all 837 encounters. It is within this loop that the health plan is required to report themselves as an Other Payer. The health plan's 9-digit Payer ID assigned by MDCH should be reported in NM109 Other Payer Primary Identifier. For MHPs/SHPs this number is your identification number assigned by MDCH that begins with 17 (17XXXXXXX). In the event that there are other payers identified as having financial responsibility for the services being reported, the health plan would report them in subsequent iterations of Loop 2330B. For other commercial payers, the MDCH carrier code list should be used. The MDCH assigned carrier codes can be accessed as follows: http://www.michigan.gov/mdch > Providers > Information for Medicaid Providers > Third Party Liability > Carrier ID Listing. Questions related to the carrier IDs should be emailed to TPL_Health@Michigan.gov. If the Other Payer is Medicare Part A (United Government Services) use the value "00452". If the Other Payer is Medicare Part B (Wisconsin Physician Services) use the value "00953". This information is addressed in the Data Clarification Documents.

M.2 Question: **Loop 2330B, NM108 Identification Code Qualifier (Other Payer Name) and Loop 2330B, NM109 Other Payer Primary Identifier. Are the Medicaid health plans required to complete this segment and data elements? (1-28-03)**

Response: Health plans are required to report Loop 2330B Other Payer Name NM108 Identification Code Qualifier Other Payer Name and NM109 Other Payer Primary Identifier. The health plan would identify themselves as a payer in one iteration of Loop 2330B and any additional payers in subsequent iterations of the loop.

M.3 Question: **Loop 2330B, REF01 Reference Identification Qualifer (Other Payer Secondary Identification and Reference Number) and REF02 Other Payer Secondary Identifier. Are the Medicaid health plans required to complete this segment and data elements? (1-28-03)**

Response*:* Health plans are required to report Loop 2330B REF01 Reference Identification Qualifier Other Payer Secondary Identification and Reference Number and REF02 Other Payer Secondary Identifier. The health plans are required to report in REF02 the plan assigned unique encounter reference number for the encounter.

M.4 Question: **Loop 2330B, REF01 Reference Identification Qualifier (Other Payer Prior Authorization or Referral Number). Are the Medicaid health plans required to complete this segment and data elements? (1-28-03)**

Response: Loop 2330B Other Payer Name, REF01 Reference Identification Qualifier Other Payer Prior Authorization or Referral Number and REF02 Other Payer Prior Authorization or Referral Number are situational elements. They are used when the payer identified in this loop has given a prior authorization or referral number for services reported on this claim. Therefore, this is the health plan or another payer's assigned Prior Authorization or Referral number. MDCH does not require health plans to submit this data element at this time.

M.5 Question: **837 Institutional Loop 2330D, REF01 Reference Identification Qualifier (Other Payer Attending Provider Identification) and REF02 Other Payer Attending Provider Identification. Are the Medicaid health plans required to complete this segment and data elements? (1-28-03)**

Response: Loop 2330D Other Payer Attending Provider, REF01 Other Payer Attending Provider Identification Qualifier and REF02 Other Payer Attending Provider Identification are not required at this time.

M.6 Question: **I require further clarification regarding MDCH's usage of the SBR segment. If this is a Medicaid claim and there is no other payer, how is it that MDCH would possibly be considered secondary? Who would be the health plan that we are supposed to document in Loop 2320 as the primary payer if there is no other payer? (3/10/03)**

Response: Due to the contractual agreement as a Medicaid health plan, the plan is the primary payer. Plans are required to send encounter data to MDCH for beneficiaries enrolled in the Medicaid Health Plan via the 837 transactions, not for payment of a claim (they have already received a capitation payment from MDCH for each Medicaid member). MDCH is considered the destination payer.

The plan's capitated arrangement with MDCH makes the plan a payer for services provided to Medicaid beneficiaries enrolled in the Medicaid health plan and therefore reported as such in the 837 encounter. The ANSI X12N 837 format and the provider-to-payer-to-payer reporting model adopted by MDCH requires that MDCH be identified as the destination payer in Loop 2010BB and the plan as an Other Payer in Loop 2330B. The hierarchy would be as follows:

2000B - Subscriber
2010BA - Subscriber Name
2010BB - Payer (MDCH)
2000C - Patient (Not Likely to Apply)
2010CA - Patient Name (Not Likely to Apply)
2300 - Claim
2310B - Rendering Provider
2310C - Service Facility
2320 - Other Subscriber Information - As an Other Payer identified in Loop 2330B, there would be

one iteration of this loop that would report information specific to the plan. The loop would be repeated as applicable for any other payers reported in an iteration of 2330B.

2330A - Other Subscriber Name

2330B - Other Payer Name – Plan information in one iteration, and if applicable, any other identified carriers in subsequent iterations.

2400 - Line Counter

2430 - Line Adjustment Information - MDCH expects this loop to be populated for each payer identified in Loop 2330B that has adjudicated the claim and applied service line adjustments. Therefore, the plan's adjudication information would be reported. MDCH has made the reporting of financial data elements voluntary through September 31, 2003.

The same information is not being reported in Loops 2000B Subscriber Hierarchical Level and 2320 Other Subscriber Information, as there are differences such as internal identifiers, policy numbers, etc. The health plan specific information does not mirror the MDCH specific information.

M.7 Question: **The possible error messages for 837 encounters includes the following:**
#20052 There is an invalid combination of Other Payer Primary Identifiers. The valid combinations are:
*** Exactly one MQHP, CA, or PHP**
*** Exactly one PHP and one CMHSP**
Any other combination of Other Payer Primary Identifiers (including none or more than two) is ambiguous and will cause this error.

We received this error on business-to-business testing. We think it's because we sent the wrong code to identify ourselves, resulting in no valid Other Payers being sent. But seeing this leads to another question.

We believe that we are a MQHP. This seems to say that if we send information about our payments, which we assume we should do, we would not be able to send information about any other payer, including other insurance that the member may have. That seems to be contradictory to other information we have received. We have been told at several times and places that we should be sending information about all other insurance coverage of which we are aware. (3/10/03)

Response: Your plan will always be identified as an Other Payer in Loop 2330B, NM109. There will be additional iterations of this loop for any additional payers. The level of responsibility of the other payer(s) identified in Loop 2330B is addressed in Loop 2320, SBR segment. SBR01 allows options of primary, secondary and tertiary. This loop will be used once for the capitated plan, and once for each additional payer identified in Loop 2330B. The level of responsibility defined in SBR01 applies to the payer that is identified in the 2330 Loop of that particular iteration of the 2320 Loop.

MDCH is not included in these loops, but instead, as the Destination Payer in Loop 2000B (Professional and Institutional), Loop 2010 BB (Professional) and Loop 2010BC (Institutional).

Please see the MDCH Data Clarification Documents, 2320-Other Subscriber Information, Subscriber Information for additional information.

N. Service Line Information

N.1 Question: **837 Instituional Loop 2400, DTP Assessment Date. Will MDCH require the health plan to submit this information? (1-28-03)**

Response: Loop 2400 Service Line Number, DTP Assessment Date is a situational data element and not required by MDCH for encounter reporting at this time.

N.2 Question: **837I – Loop 2430 Service Line Adjudication Information. Are the Medicaid health plans required to complete this segment and data elements? (1-28-03)**

Response: MDCH requires Loop 2430 Service Line Adjudication Information to be reported for 837 Institutional and Professional encounters for each payer identified in Loop 2330B Other Payer Name that has adjudicated the claim and applied service line adjustments. Therefore, the health plan adjudication and any other payer adjudication would be required to be reported in Loop 2430 Service

Line Adjudication Information. Adjudication that is done at the claim level, such as often done for inpatient hospital claims, would be reported at the claim level and not be expected to be reported at the service line.

N.3 Question: **The following values do not appear to be available on our existing system. We can work to start collecting this information in the future but have no timeframe when the information would be available. Will we fail compliance if the following information is not provided? (1-28-03)**

CAS01 - CLAIM ADJUSTMENT GROUP CODE

SVD Loop 2430 - SERVICE LINE ADJUDICATION INFORMATION

Response: Loop 2320 Other Subscriber Information and Loop 2430 Service Line Adjudication Information CAS01 Claim Adjustment Group Code are required to be reported when claim level or service line level adjustments are being reported. Loop 2430 Service Line Adjudication Information SVD Service Line Adjudication is required to be reported on all 837 encounters where the claim has been adjudicated by the Other Payers identified in Loop 2330B (including the health plan) and service line adjustments have been made. Although reporting financial data elements are optional until October 2003, there are other critical data elements in the SVD segment that the health plan is required to report, such as revenue code, procedure code, modifier(s), and quantity.

N.4 Question: **In a conference call attended by an employee in October or November, it was mentioned that the State was looking into having the fee schedule amount reported in the AMT 2400 segment. Has a final decision been made on this requirement? Does it need to be sent? (1-28-03)**

Response: Reporting Loop 2400 AMT02 (Approved Amount) is optional until October 2003. MDCH will populate this field with the Medicaid fee screen amount when the contract arrangement between the health plan and provider is subcapitated. The health plan is expected to populate Loop 2400 AMT02 with their fee schedule amount in those instances where the contract arrangement with the provider is fee-for-service.

O. Interchange Control and Functional Group Information

O.1 Question: **Will the plans need to use DEG style headers and trailers in addition to the standard X12 headers and trailers? (9/20/02)**

Response: No additional headers or trailers beyond the standard X12 headers and trailers will be needed.

O.2 Question: **What values should be placed in the ISA and GS segments to identify the plan? (1-28-03)**

Response: ISA05 Interchange ID Qualifier and ISA06 Interchange Sender ID identify the sender in the Interchange Control Header. The health plan as sender should report a value of "ZZ" in ISA05. The health plan should report the Interchange Sender ID in ISA06 as follows: Positions 1-4 your billing agent ID number, for example "00XX", and positions 5-15 space fill. The sender is again identified in the Functional Group Header in GS02 Application Sender's Code. The health plan should report their billing agent ID number.

O.3 Question: **Is the requirement for ENCOUNTER in the ISA08 segment and GS03 segment(s) temporary for testing or will that remain in the future? (1-28-03)**

Response: The requirement that the health plan use the value "ENCOUNTER" in the ISA08 and GS03 is permanent for encounter transactions, and not just for testing.

P. Integrity Testing

P.1 Question: **How long does the HIPAA certification process take? (9/20/02)**

Response: A plan can receive certification the same day the file is transmitted to Claredi. However, it is not expected that most plans will pass on submission of the first file. MDCH is recommending that plans test through the Internet process first. This should facilitate the Claredi testing and certification process.

P.2 Question: **If a plan transfers to a new subsidiary with a new tax ID, will they need to be re-certified? (9/20/02)**

Response: If there is a tax ID change or a system change, the plan will need to be re-certified.

P.3 Question: **We have submitted files to Claredi and have received errors for missing fields. However, these are fields that were not required on the proprietary format and are not included in the crosswalks in the *MDCH Supplemental Instructions for Encounter Data Submission Manual* (1-28-03)**

Response: All health plans need to abide by the requirements as stated in the 837 Implementation Guides. The crosswalks provided in the *MDCH Supplemental Instructions for Encounter Data Submission Manual* were to assist the plans in understanding where the data required in the proprietary format should be placed. However, additional data will be required in the 837 and plans need to follow the requirements as stated in the 837 Implementation Guide.

Q. Implementation Schedule

Q.1 Question: **I understand providers and contracted health plans will be testing with the State in January. Will there be a period where both formats will be accepted, or is it full production with 837 for the February submission? (1-28-03)**

Response: All non-pharmacy services incurred on or after January 1, 2003 must be submitted in the new 837 formats. Services incurred in 2002 may be submitted using the 837 formats or health plans may continue to submit these 2002 encounters using the proprietary format until May 1, 2003. Any replacement or void of an encounter that was accepted into the MDCH data warehouse must be submitted using the same format. Replacements or voids to encounters originally submitted in the proprietary format will only be allowed until May 1, 2003. At this time, health plans should continue to submit prescription drug encounters using the proprietary format. The Department will update the health plans on the status of the HIPAA compliant NCPDP version as information becomes available.

Q.2 Question: **Will the state of Michigan be using the addendum to the 837 implementation guides? (3-10-03)**

Response: The February 2003 implementation of the ANSI ASC X12N 837 format for encounters does not include the 837 Addenda. The Department is addressing this issue and will update the health plans as information becomes available.

Q.3 Question: **Will a sanction be imposed by MDCH if a health plan does not successfully transmit their non-pharmacy January data in the 837 formats by February 15, 2003? (1-28-03)**

Response: Encounter data monitoring currently includes both timeliness and volume requirements. MDCH will continue to monitor timely encounter submissions by the 15th of the month. However, MDCH will not require minimum volume requirements during a three-month "grace period" that will include monthly submissions during February, March and April 2003. For the month of February 2003, business-to-business testing will demonstrate a good faith effort by the plans.

Q.4 Question: **I would like to verify that if we submit prior to the 15th of March and April, in the 837 format, we will meet the minimum requirements regardless of the volume that we submit, as there is no minimum during this grace period. If we submit only professional records in March and April, do we still meet the requirements or do we have to submit both professional and institutional records? (3/10/03)**

Response: To meet the timeliness requirement, plans must submit and have accepted into the warehouse a production Professional and/or Institutional transaction by March 17, 2003 (the 15th falls on Saturday). To meet the April timeliness requirement, the plan must successfully complete B2B testing and submit both a Professional and Institutional production file by April 15, 2003. MDCH will not monitor overall volume or volume for any particular record category (e.g. professional or institutional) during the months of February, March and April 2003. However, plans are still responsible for submitting all historical records so that services can be accurately represented.

***Q.5 Question*: When are plans required to send production 837 encounter data? Is it March or will B2B testing still be acceptable for March? (3/10/03)**

***Response**:* Plans are expected to submit production data by the March submission deadline. MDCH will accept B2B testing for timeliness in February only.

***Q.6 Question:* The FAQ document that came out of the HIPPA/encounter meeting a few weeks ago says that data with incurred dates on or after January 1, 2003 must be sent in the 837 format and data with incurred dates prior to 1/1/03 may be sent in the proprietary format until May 1, 2003. Can you please clarify this? We have always sent our encounter data based on Paid Date, not incurred date. If some of our 2002 data were included in our 837 file, would this be a problem? (3/10/03)**

Response: Non-pharmacy encounters incurred on or after 1/1/2003 must be submitted in the 837 formats. Additionally, non-pharmacy encounters incurred prior to 1/1/2003 may be submitted in the proprietary format up to 5/1/03. However, if not previously submitted in the proprietary format, these non-pharmacy "original" services incurred in 2002 may be sent in the 837 formats rather than the proprietary format.

If you have previously submitted encounter data based on paid date, rather than incurred date, MDCH would suggest the following options:

1. If the encounter has not yet been submitted to MDCH (i.e. original encounter), submit it in the 837 format. This would include 2002 services. However, please keep in mind, if the record is a correction (i.e. - void or replacement) of an encounter that was previously submitted in the proprietary format, the correction must be submitted in the proprietary format and must be submitted prior to 5/1/03.
2. Since you utilize "paid date" in the submission process, submit any encounters paid/processed in 2002 in the proprietary format (these can be submitted in the proprietary format up to 5/1/2003), and any encounters paid/processed in 2003 in the 837.

***Q.7 Question:* Assuming it is after May lst and we receive an encounter or claim with DOS older than 1 year, should these be submitted in 837 format? (3/10/03)**

Response: These encounters should be submitted in the 837 formats.

***Q.8 Question:* Which format would the State like to use for history requested information? (3/10/03)**

Response: Non-pharmacy encounters with dates of service 1/l/2003 and after must be submitted in the 837 formats. “Original” non-pharmacy encounters with dates of service prior to l/1/2003 may be submitted in the 837 format at any time, or in the proprietary format until 5/l/03. If the record is a correction (i.e. - void or replacement) of an encounter that was previously submitted in the proprietary format, the correction must be in the proprietary format and must be submitted prior to 5/l/03. Regardless of date of service, non-psychotropic pharmacy encounters should continue to be submitted in the proprietary format until further notice.

R. Business-to-Business (B2B) Testing

***R.1 Question:* Will the MDCH team or someone provide documentation that we have passed and are cleared for Production submissions? (1/28/03, Revised 3/10/03)**

Response: MDCH will send health plans a confirming, congratulatory e-mail once testing activities are complete and MDCH is ready to accept the X12 v 4010 transactions from that health plan. Additionally, when you have successfully completed B2B testing for the 837 Institutional and 837 Professional encounters you will receive a letter from the Department. The letter will not be sent until both the Institutional and the Professional B2B encounter testing is complete.

Loop Crosswalk to FAQ

Question	1000	2000	2010	2300	2305	2310	2320	2330	2400	2430
B.1	X									
C.2						X				
D.1		X	X				X			
D.2		X					X			
D.3		X								
E.1			X							
F.1		X								
G.5				X						
G.6				X						
G.7				X						
G.8				X						
G.9				X						
G.10				X						
G.11				X						
G.12				X						
G.13				X				X		
G.14				X						
G.15				X						
G.16				X	X					
G.18				X						X
G.19				X						
G.20				X						
G.21				X						
G.22				X						
G.23				X						
G.24				X						
G.25				X						
G.27				X						
H.1						X				
I.1						X				
I.2						X				
I.3					X					
J.1			X			X				
K.1			X			X				
L.1							X	X		
L.2								X		
L.3								X		
M.1								X		
M.2								X		
M.3								X		
M.4								X		
M.5								X		
M.6		X	X	X		X	X	X	X	X
M.7		X	X				X	X		
N.1									X	
N.2										X
N.3							X	X		X
N.4									X	